STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE OF CASTLETON	8480 CRAIG ST INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: March 5, 6. 7, 2012 Facility number: 009894 Provider number: 009894 AIM number: N/A Survey team: Connie Landman RN TC Census bed type: Residential: 125 Total: 125 Census payor type: Other: 125 Total: 125 Sample: 8 This State Residential finding is cited in accordance with 410 IAC 16.2. Quality review 3/08/12 by Suzanne Williams, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0414	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review and interview, the facility failed to ensure staff washed their hands during medication administration for 1 of 2 medication pass observations. This deficient practice had the potential to affect 55 of 125 residents in the facility. (LPN #1, Residents #85, #86, #90) Findings include: During the medication pass observation on the second floor on 3/5/12 at 3:40 P.M., LPN #1 was observed in the Wellness Center. At that time, she indicated she was going to administer 4:00 P.M. medications. She carried the binder which contained the MARs (Medication Administration Records) with her. LPN #1 approached Resident # 85's door, and knocked on the door. LPN #1 indicated he must not be in his apartment as there was no answer. LPN #1 knocked on Resident #86's door, and it was answered. LPN #1 entered the apartment, obtained the locked	R0414	**The following is the Plan of Correction for Berkshire of Castleton in regards to the Statement of Deficiencies for the annual survey completed on 3-7-121. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.** **R 414 Infection Control** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · No residents were affected by the alleged deficient practice. LPN # 1 was re-educated on the existing policy for Medication administration hand washing. This training was provided by the Assistant Health and Wellness Director on 3-6-12. ***How will the facility identify other***	04/01/2012

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	medication tote, unlocked the lock, and removed the 4:00 P.M. medication which was a Viactiv Chew. LPN #1 opened the wrapper, and handed the medication in the wrapper to the resident. LPN #1 initialed the MAR, locked the medication tote, and left the apartment. LPN #1 then approached the apartment door of Resident #90. Resident #90 was present, and LPN #1 entered the apartment. LPN inquired if the resident was feeling better, and both indicated the resident had been under the weather. It had left the resident weak and frail for a while, but the resident's appetite had started returning. LPN #1 then obtained the locked tote for Resident #90, unlocked it, and placed 2 Fish Oil capsules, 1 Metoprolol tablet, and 1 Vitamin D3 capsule in a plastic medication cup, and gave it to the resident. LPN #1 initialed the MAR, locked the tote, and left the apartment. At that time, LPN #1 indicated she was going to continue the 4:00 P.M. medication pass. No hand washing or use of hand gel was observed prior to LPN #1 leaving the Wellness Center to the end of the medication pass observation. During an interview with the AHWD		***residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Residents who receive medication administration services from nursing have the potential to be affected by the alleged deficient practice. · Re-education regarding proper hand washing was provided to other nursing associates by the Assistant Health and Wellness Director and Designee. ***What measures will be put in place or what systemic changes will be implemented to ensure the alleged deficient practice does not recur?*** · The Health and Wellness Director/Designee has posted reminders regarding proper hand washing practices in the Wellness Centers. · The 20 second hand washing rule will be part of the orientation training requirement for new associates who will be administering medications. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director/Designee will monitor hand washing practices daily each shift and document the findings for two weeks. · The hand washing monitoring will continue each shift daily for the next two weeks and monthly thereafter. · Results of the audits are to be provided to the Executive Director monthly for review. · Additional actions will be	

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	(Assistant Health and Wellness Director) on 3/7/12 at 9:20 A.M., she indicated LPN #1 had informed her she had "messed up" by not washing her hands between each resident as she was giving the medications during the medication pass observation. The AHWD indicated the staff knew better than that. A current facility policy, dated June, 2002, and last revised 12/07, titled "Hand Washing - Associates", provided by the AHWD on 3/7/12 at 8:30 A.M., indicated: "Purpose: Handwashing is regarded as the single most important means of preventing the spread of infections. All associates should wash their hands to prevent the spread of infection and disease to other residents, other associates, and visitors. Suggested guidelines: 1. Appropriate fifteen (15) to twenty (20) second hand washing should be performed in situations including but not limited to: ... Before preparing or handling medications.... Antimicrobial Hand Gels: ... 2. Use alcohol-based rubs after any direct contact with any resident, after having direct contact with a resident's skin, after having contact with body fluids, wounds or broken skin, after		determined by the Executive Director, based on findings. ***By what date will these systemic changes be implemented?*** · 4-1-12	

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	touching equipment or furniture near the resident, and after removing gloves...."			